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Report for:	Health and Wellbeing Board – 23rd February 2016
Title:	Social Prescribing
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1. Describe the issue under consideration

1.1 This report introduces the concept of social prescribing, describes various models and the evidence base behind the models and summarises the rationale underpinning the approach.

1.2 The HWB is asked to discuss our strategic approach to social prescribing and the model to adopt that would best suit our local landscape and our diverse communities.

2. Cabinet Member Introduction

2.1 Improving access to primary and community care and enriching the local offer of interventions that are community based is one of the ambitions clearly articulated in Haringey's Health and Wellbeing Strategy.

2.2 Developing a local social prescribing approach for Haringey across the whole system would be an important step towards delivering that ambition. It is a real opportunity for the CCG, the council, local GPS and healthcare professionals to work together to improve community health.

3. Recommendations

3.1 The Board agrees that social prescribing is the right approach for Haringey.

3.2 The Board establishes a 'task and finish' group – including representatives from the CCG, primary care, Haringey Council, Healthwatch and a range of providers already delivering some aspects of social prescribing in the borough – to scope our local model to best suit our landscape and existing services across the borough.

4. Background information

4.1 Approximately 70% of health outcomes are determined by socio-economic factors and 30% by clinical factors (Marmot 2010). Social prescribing seeks to address this by offering referral into non-clinical services coupled with support to engage with these services, which range from arts and culture to physical exercise, benefits and debt advice, cookery classes, etc.

4.2 "Social prescribing is a mechanism of linking patients into non-clinical services usually linked to primary care and/or linking clients into support from within the community to promote their health and wellbeing, to encourage social inclusion, to promote self-care, where appropriate, and to build resilience within the community and for the individual" (Social Prescribing in Bristol Working Group, 2012). Social prescribing models focus on factors that positively support health and well-being rather than on factors that cause disease—and promotes a more holistic, community-centred model of primary and community care.

4.3 There are a number of different models of social prescribing across the country, as described in Appendix I. The table below describes the most common models and the pros and cons related to each model:

Social prescribing model	Pros	Cons
GPs playing a role in signposting to a range of non-clinical services;	Minimal additional workload for GP/primary care staff Patient-driven contact with VCS Inexpensive model as it does not require additional staff	Reduced likelihood of uptake by patients GPs and practice staff difficulty in maintaining awareness of diversity of services available Some GPs may not yet be accepting of social prescribing as a viable care route. No feedback from VCS Difficult to evaluate
GPs prescribe patients to a specific activity, with some models extending to allow referrals from other professionals including voluntary sector and social care;	Patient trust/familiarity of GP and other professionals Inexpensive More formalised, may increase uptake compared to signposting alone	GP not necessarily ideally placed to refer to community resources due to the additional time needed to consult with patients to identify appropriate services Reduced likelihood uptake amongst patients

		GP unlikely to have time to stay up to date with the range of available services and providers. No feedback from VCS Difficult to evaluate
Referral from GPs/other professionals to a link worker who would provide support and advice on the most appropriate set of activities based on individual needs.	Reduced burden to primary care staff to maintain contact/awareness of VCS services available ‘One stop shop’ for patients/health professionals and increased uptake Better patient care – time for link worker to identify most appropriate service using *local* knowledge and access to directories – can be developed into “holistic” model, in which link worker assesses whole person needs not just those raised by GP. Patient-centred. Other health and social care workers, especially domiciliary workers and healthcare assistants might be well placed to advocate schemes to older adults and/or mental health service-users at risk of social isolation. Link worker one to one sessions (e.g. up to 6 one hour sessions) has therapeutic effect Initial VCS activities may be subsidised/funded, longer term patients contribute financially to VCS Link worker may join part of	Requires clarity on which care pathways a social prescribing scheme would fit into/address. Requires investment for link worker if not integrated within already existing services Requires time to develop trusting partnerships between health/VCS sector. All “famous” SP initiatives evolved from the other “lighter” models – not an instant bolt on, a long term commitment. Difficult to evaluate

	multi-disciplinary team, providing feedback to health/social care professionals Social care, charities, other health professionals may also be able to refer	

4.4 The evidence of effectiveness of social prescribing models in terms of improving health outcomes and reducing hospital and GP activity varies in relation to specific health conditions and the way social prescribing models are delivered. In general, the evidence of effectiveness seems to be stronger in patients who have long-term conditions and mental ill health. The Rotherham Social Prescribing Pilot (2012) has identified a clear overall trend in reduced hospital usage with 21% fewer admissions, 14% fewer A&E attendances and 21% fewer outpatient appointments in those followed up twelve-months post-referral compared to twelve months pre-referral (Sheffield Hallam University, *The Social and Economic Impact of the Rotherham Social Prescribing Pilot: Summary Report*, 2014). Eighty three percent of those followed up three to four months post-discharge had experienced positive change in at least one social outcome area (e.g. money, family and friends, managing symptoms, lifestyle etc). However, only 40% of social prescribing programmes have been evaluated and available evidence is methodologically limited by the lack of a comparator group, resulting in a high risk of bias. Outcomes may vary depending on type of services offered and extent of link worker involvement. There is a need to clarify outcomes expected and to discuss with the voluntary and community sector about how best to collect monitoring data.

4.5 The social prescribing concept is not new for Haringey and there is a range of interventions already in place that would form part of the network of our local model:

- Pilot project in JS Medical Practice
- Neighbourhood Connects
- Time Credit
- Bound Green Road practice – initiatives delivered by Patient Participation Group
- Welfare hubs in GP practices
- IAG
- Integrated wellness service
- Locality co-ordinators
- Cultural and Creative Industries Strategy
- Primary Care Strategy
- NCL Estate devolution
- Healthwatch workshop

5. **Contribution to strategic outcomes**

Community Strategy, Priority 2 of the Corporate Plan and Ambition 5 of the Health and Wellbeing Strategy.

6. **Statutory Officers comments (Chief Finance Officer (including procurement), Assistant Director of Corporate Governance, Equalities)**

Finance and Procurement

6.1 This is a discussion paper and, as such, there are no recommendations for action that have direct financial implications.

Legal

6.2 This is a discussion paper and, as such, there are no recommendations for action that have a direct legal implication.

Equalities

6.3 The Council has a public sector equality duty under the Equalities Act (2010) to have due regard to:

- tackle discrimination and victimisation of persons that share the characteristics protected under S4 of the Act. These include the characteristics of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex (formerly gender) and sexual orientation;
- advance equality of opportunity between people who share those protected characteristics and people who do not;
- foster good relations between people who share those characteristics and people who do not.

6.4 Social prescribing models aim to deliver better health outcomes for all of Haringey's residents, particularly those that have long-term conditions or poorer mental health.

7. **Use of Appendices**

Appendix I: Social Prescribing for Health and Wellbeing presentation

8. **Local Government (Access to Information) Act 1985**

Not applicable